

504

MARYLAND STATE DEPARTMENT OF HEALTH

00495

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY <i>Harlem</i> <i>Charles County</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>TOWN</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Harlem</i> COUNTY <i>Charles</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>TOWN</i> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <i>Francis</i> (Middle) <i>Richard</i> (Last) <i>Adams</i>		4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>23</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>10/15/1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brigman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Business</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>John Adams</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		17. INFORMANT AND ADDRESS <i>Miss Edgar P. Miller, 1212 N. 1st St.</i>	
16. SOCIAL SECURITY No. <i>None</i>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <i>Coronary Thrombosis</i>		<i>1 hour</i>	
Antecedent cause(s) (b) <i>Coronary Sclerosis</i>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office, etc.) <i>Home</i>		CITY OR TOWN <i>Harlem</i> COUNTY <i>Charles</i> (STATE) <i>Md.</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <i>None</i>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy (Inspection or Inquiry), find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <i>William J. Kier, M.D.</i>		DATE SIGNED <i>1/23/56</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>1/26/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Harlem Baptist</i>		LOCATION (City, town, or county) <i>Harlem</i> (State) <i>Md.</i>	
DATE REC'D BY LOCAL REG. <i>1/24/56</i>		24. FUNERAL DIRECTOR <i>Hunt, Funeral Home, 1212 N. 1st St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 26 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00496

CERTIFICATE OF DEATH

Reg. Dist. No. 100

505
Items 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF COURT

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

BUREAU V. S.

JAN 9 1956

RECEIVED

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00497

506

CERTIFICATE OF DEATH

Items 4, 8 Film G201, 8-21-56, E.J.

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN La Plata		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Issue			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) Baby "B" Butler				4. DATE OF DEATH (Month) January (Day) 21 (Year) 1956			
5. SEX Male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH 2 January 1, 1956	9. AGE last birthday yrs. 5		IF UNDER 1 YEAR Months 2 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Milton Thomas				14. MOTHER'S MAIDEN NAME Agnes Viola Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Viola Butler			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
776X IMMEDIATE CAUSE (A) Perinatal (extreme)						6 hrs.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-56 , 1956 , to 1-1-56 , 1956 , that I last saw the deceased alive on 1-1-56 , 1956 , and that death occurred at 7:30 p.m. , from the causes and on the date stated above.							
SIGNATURE Frederick Johnson M.D.				ADDRESS (Street, city, town, state) La Plata, Md.		DATE SIGNED 1-3-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/4/56		NAME OF CEMETERY OR CREMATORY Holy Ghost		LOCATION (City, town, or county) (State) Issue, Md.	
24. REC'D BY REGISTRAR 1/4/56		REGISTRAR'S SIGNATURE Julius H. Posey		25. FUNERAL DIRECTOR'S SIGNATURE Louis Butler		ADDRESS Archibald Funeral Home, La Plata	

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ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE	
19. SIGNATURE OF JAILER		20. SIGNATURE OF WARDEN		21. SIGNATURE OF CHIEF CLERK	
22. SIGNATURE OF CHIEF OF POLICE		23. SIGNATURE OF DEPUTY CHIEF OF POLICE		24. SIGNATURE OF SQUAD LEADER	
25. SIGNATURE OF OFFICER		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF PATROLMAN	
28. SIGNATURE OF TRAFFIC OFFICER		29. SIGNATURE OF INVESTIGATOR		30. SIGNATURE OF ADJUTANT	
31. SIGNATURE OF CLERK		32. SIGNATURE OF RECEPTIONIST		33. SIGNATURE OF TELEPHONE OPERATOR	
34. SIGNATURE OF MAIL ROOM		35. SIGNATURE OF RECORDS SECTION		36. SIGNATURE OF IDENTIFICATION SECTION	
37. SIGNATURE OF LABORATORY		38. SIGNATURE OF RADIOLOGY		39. SIGNATURE OF PATHOLOGY	
40. SIGNATURE OF ANATOMY		41. SIGNATURE OF HISTOLOGY		42. SIGNATURE OF CYTOLOGY	
43. SIGNATURE OF MICROBIOLOGY		44. SIGNATURE OF IMMUNOLOGY		45. SIGNATURE OF PHARMACOLOGY	
46. SIGNATURE OF TOXICOLOGY		47. SIGNATURE OF CLINICAL CHEMISTRY		48. SIGNATURE OF CLINICAL PHYSIOLOGY	
49. SIGNATURE OF CLINICAL PSYCHOLOGY		50. SIGNATURE OF CLINICAL NEUROLOGY		51. SIGNATURE OF CLINICAL RADIOLOGY	
52. SIGNATURE OF CLINICAL PATHOLOGY		53. SIGNATURE OF CLINICAL LABORATORY		54. SIGNATURE OF CLINICAL RESEARCH	
55. SIGNATURE OF CLINICAL EDUCATION		56. SIGNATURE OF CLINICAL TRAINING		57. SIGNATURE OF CLINICAL SUPERVISION	
58. SIGNATURE OF CLINICAL MANAGEMENT		59. SIGNATURE OF CLINICAL ADMINISTRATION		60. SIGNATURE OF CLINICAL FINANCE	
61. SIGNATURE OF CLINICAL LEGAL		62. SIGNATURE OF CLINICAL ETHICS		63. SIGNATURE OF CLINICAL HISTORY	
64. SIGNATURE OF CLINICAL PRESENTATION		65. SIGNATURE OF CLINICAL EXAMINATION		66. SIGNATURE OF CLINICAL TREATMENT	
67. SIGNATURE OF CLINICAL FOLLOW-UP		68. SIGNATURE OF CLINICAL EVALUATION		69. SIGNATURE OF CLINICAL REVISION	
70. SIGNATURE OF CLINICAL CLOSURE		71. SIGNATURE OF CLINICAL REOPENING		72. SIGNATURE OF CLINICAL REENTRY	
73. SIGNATURE OF CLINICAL REEXIT		74. SIGNATURE OF CLINICAL REENTRY		75. SIGNATURE OF CLINICAL REENTRY	
76. SIGNATURE OF CLINICAL REENTRY		77. SIGNATURE OF CLINICAL REENTRY		78. SIGNATURE OF CLINICAL REENTRY	
79. SIGNATURE OF CLINICAL REENTRY		80. SIGNATURE OF CLINICAL REENTRY		81. SIGNATURE OF CLINICAL REENTRY	
82. SIGNATURE OF CLINICAL REENTRY		83. SIGNATURE OF CLINICAL REENTRY		84. SIGNATURE OF CLINICAL REENTRY	
85. SIGNATURE OF CLINICAL REENTRY		86. SIGNATURE OF CLINICAL REENTRY		87. SIGNATURE OF CLINICAL REENTRY	
88. SIGNATURE OF CLINICAL REENTRY		89. SIGNATURE OF CLINICAL REENTRY		90. SIGNATURE OF CLINICAL REENTRY	
91. SIGNATURE OF CLINICAL REENTRY		92. SIGNATURE OF CLINICAL REENTRY		93. SIGNATURE OF CLINICAL REENTRY	
94. SIGNATURE OF CLINICAL REENTRY		95. SIGNATURE OF CLINICAL REENTRY		96. SIGNATURE OF CLINICAL REENTRY	
97. SIGNATURE OF CLINICAL REENTRY		98. SIGNATURE OF CLINICAL REENTRY		99. SIGNATURE OF CLINICAL REENTRY	
100. SIGNATURE OF CLINICAL REENTRY		101. SIGNATURE OF CLINICAL REENTRY		102. SIGNATURE OF CLINICAL REENTRY	

BUREAU V. S.

JAN. 9. 1936

RECEIVED

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM
RECEIVED
JAN. 9. 1936
BUREAU V. S.

1

INSTRUCTIONS

1 executed within **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00498

507

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		STATE <u>MARYLAND</u>		COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HUGHESVILLE</u>		<u>509S</u>		TOWN <u>HUGHESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>LILLIAN</u> (First) <u>MAE</u> (Middle) <u>CANTER</u> (Last)				4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W - U.S.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 8, 1876</u>		9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD T. LUSBY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA JANE ALLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. PAUL LONG</u> <u>HUGHESVILLE, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> ANTECEDENT CAUSE(S) DUE TO <u>(ACUTE LEFT VENTRICULAR FAILURE)</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>GENERALIZED ARTERIO-SCLEROSIS</u> (C) _____						<u>2 WEEKS</u> <u>10 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/14</u> , 19 <u>56</u> , to <u>1/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>56</u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Guffin</u> M.D.				ADDRESS (Street, city, town, state) <u>HUGHESVILLE, MD</u>		DATE SIGNED <u>1/30/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Old Field</u>		LOCATION (City, town, or county) (State) <u>Hughesville, MD</u>	
24. REC'D BY REGISTRAR <u>2/1/56</u>		REGISTRAR'S SIGNATURE <u>Julia W. Passey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The South Funeral Home</u>		ADDRESS <u>Hughesville, MD</u>	

CERTIFICATE OF DEATH

REG. DIST. NO.

1. FULL RESIDENCE (HUSBAND & WIFE)

MARYLAND

COUNTY OF

TOWNSHIP OF

WARD OF

PRECINCT OF

STREET

APARTMENT

PO BOX

ZIP CODE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

MODE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF DISPOSITION

PLACE OF DISPOSITION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. S.

FEB 3 1956

RECEIVED

RECEIVED
FEB 3 1956
BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

508
Item 21 Film 6122 2-2-50 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00499
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Waldorf</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Bryantown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>LOUIS</u>		(Middle) <u>McKINLEY</u>		(Last) <u>EDELEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 19 1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>9-26-1925</u>	9. AGE last birthday: <u>30</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Bernard Cook</u>				14. MOTHER'S MAIDEN NAME: <u>Mary (Maiden name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>213-26-4799</u>		17. INFORMANT & ADDRESS: <u>Sheriff office, Charles County, Maryland</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1-19-56</u>	
<u>929.3</u> Immediate cause (a) <u>DROWNED</u> Antecedent cause(s) (b) <u>Slipped on ice at edge of swimming pool & fell in. Water was 8' deep.</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Home & Farm</u>		21c. (City or town) (County) <u>Charles</u> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Slipped on ice at edge of swimming pool & fell in. Water was 8' deep.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>L. E. Edelen</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-23-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bryantown, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Julia H. Casey</u>		24. FUNERAL DIRECTOR <u>The Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

BUREAU A. S.

JAN 25 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00500

Reg. Dist.

No. 105

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>WALDORF</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Waldorf, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>EARL</u> (First) <u>Pembrook</u> (Middle) <u>Gates</u> (Last)				4. DATE OF DEATH 1 26 19 56			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>1-9-1898</u>	9. AGE last birthday: <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>LABORER OWNER</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>Peter P. Gates</u>				14. MOTHER'S MAIDEN NAME: <u>IDA ADAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Waldorf Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
420.1 Immediate cause (a) <u>CORONARY OCCLUSION</u> DUE TO				1-26-56			
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. H. Delaney MD.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-26-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1-28-56</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Pauls Cemetery</u>		LOCATION (City, town, or county) (State): <u>Waldorf Md</u>	
DATE REC'D BY LOCAL REG. <u>1-28-56</u>		REGISTRAR'S SIGNATURE: <u>M. L. Moore</u>		24. FUNERAL DIRECTOR: <u>Hunt Funeral Home</u>		ADDRESS: <u>Waldorf Md</u>	

BUREAU V. S.

RECEIVED
JUN 27 1957

CORONARY Occasion 1-20-55

IDA ADAMS

Peter P. Gates

EARL JENKINS GATES

CHARLES
WHL DOR F

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00501

510

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>La Plata</u>				OR TOWN <u>Bel Alton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Marian</u> (Middle) <u>Dorothy</u> (Last) <u>Goldsmith</u>				(Month) <u>Jan.</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>white</u>	<u>married</u>	<u>Nov. 9, 1908</u>	<u>47</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>self</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Pilkerton</u>				<u>Marian Oliver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Elmer Goldsmith, Bel Alton, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>						<u>4 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Squamous Cell Epithelioma of Endocervix with Multiple Metastases.</u>						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Uremia</u>						<u>1 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Intestinal Obstruction with Colostomy</u>						<u>6 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>Sept. 9, 1955</u>		<u>Acute Ileal and Colonic Obstruction; Extensive Carcinoma</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 7, 1955</u> , to <u>1-15-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-15-56</u> , 19 <u>56</u> , and that death occurred at <u>3:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Barbara Jarboe</u>				ADDRESS (Street, city, town, state) <u>La Plata, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Good Burial</u>		<u>1-17-56</u>		<u>St. Ignatius</u>		<u>Bel Alton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1/16/56</u>		<u>Julia H. Pacey</u>		<u>Huntt Funeral Home, La Plata Waldorf, Md.</u>			

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10501

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

2102

Reg. Off. No. 10501

NAME OF DECEASED

DATE OF DEATH

CHINESE
JAN 18 1956

PLACE OF DEATH
BALTIMORE, MD.

CAUSE OF DEATH
HEART DISEASE

AGE
65

SEX
MALE

EDUCATION
HIGH SCHOOL

DATE OF BIRTH
JAN 18 1956

BUREAU V. S.

JAN 18 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00502

511

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cobb Island</u>				TOWN <u>Cobb Island</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John</u> <u>Wynn</u> <u>Jacobs</u>				<u>1</u> <u>7</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>married</u>	<u>March 9 1874</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Gov</u>		<u>Washington D C</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas P Jacobs</u>				<u>Louise Boon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Agnes L Jacobs Cobb Island Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
2040 IMMEDIATE CAUSE (A)				<u>Lymphatic Leukemia</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>4-55</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4</u> <u>1956</u> , to <u>1-7</u> <u>1956</u> that I last saw the deceased alive on <u>1-7</u> <u>1956</u> , and that death occurred at <u>4</u> <u>P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. Hedden</u> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-10-56</u>		<u>Christ Church</u>		<u>Wayside Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Julia H. Casey</u>		<u>Archart Funeral Home Inc.</u>		<u>Laplace</u>	
DATE <u>1/10/56</u>							

10525

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

REG. ONE 100-1-10

1. CAUSE OF DEATH

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. AGE

13. RACE

14. OCCUPATION

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX

20. AGE

21. RACE

22. OCCUPATION

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX

28. AGE

29. RACE

30. OCCUPATION

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. AGE

37. RACE

38. OCCUPATION

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX

44. AGE

45. RACE

46. OCCUPATION

47. DATE OF DEATH

48. TIME OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX

52. AGE

53. RACE

54. OCCUPATION

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX

60. AGE

61. RACE

62. OCCUPATION

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF BIRTH

66. DATE OF BIRTH

67. SEX

68. AGE

69. RACE

70. OCCUPATION

71. DATE OF DEATH

72. TIME OF DEATH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. SEX

76. AGE

77. RACE

78. OCCUPATION

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX

84. AGE

85. RACE

86. OCCUPATION

87. DATE OF DEATH

88. TIME OF DEATH

89. PLACE OF BIRTH

90. DATE OF BIRTH

91. SEX

92. AGE

93. RACE

94. OCCUPATION

95. DATE OF DEATH

96. TIME OF DEATH

97. PLACE OF BIRTH

98. DATE OF BIRTH

99. SEX

100. AGE

BUREAU V. S.

JAN 12 1950

RECEIVED

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

512

CERTIFICATE OF DEATH

00503

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN La Plata				TOWN Bryantown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) George Jameson				4. DATE OF DEATH (Month) (Day) (Year) Jan. 11, 1956			
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 11, 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Jameson				14. MOTHER'S MAIDEN NAME Cecelia Wheatly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS M. Louise Jameson, Bryantown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A) Generalized Carcinomatosis						2 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) Adenocarcinoma of Stomach with Metastases						3 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute Intestinal Obstruction						1 week	
19a. DATE OF OPERATION Nov. 11, 1955		19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Stomach with multiple metastases				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 3, 1955 , to Jan. 10, 1956 , that I last saw the deceased alive on Jan. 10, 1956 , and that death occurred at 1:25A.M. from the causes and on the date stated above.							
SIGNATURE Harlan Jarboe M.D.				ADDRESS (Street, city, town, state) La Plata, Maryland DATE SIGNED Jan. 11, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-13-56		NAME OF CEMETERY OR CREMATORY St. Marys		LOCATION (City, town, or county) (State) Bryantown, Md.	
24. REC'D BY REGISTRAR 1/13/56		REGISTRAR'S SIGNATURE Julia H. Posey		25. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		ADDRESS	

213

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00504

513

CERTIFICATE OF DEATH

Item 8, FilmGL91 1-18-56 et

Reg. Dist. No. 105

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		STATE <u>MD.</u>		COUNTY <u>CHARLES.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL-WALDORF</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL-WALDORF.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ELNORA</u> <u>MCPHERSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 3</u> <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>1871</u> <u>Mar. 3, 1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Butler</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT & ADDRESS <u>MRS ELNORA PINKNEY</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) <u>MYOCARDIAL FAILURE</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARDIO-VASCULAR RENAL DISEASE</u>						<u>YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>_____</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>_____</u>							
19a. DATE OF OPERATION <u>_____</u>		19b. MAJOR FINDINGS OF OPERATION <u>_____</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>_____</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>_____</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>_____</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>_____</u>			
22. I hereby certify that I attended the deceased from <u>FEB. 10, 1955</u> to <u>JAN 2, 1956</u> , that I last saw the deceased alive on <u>JAN 2, 1956</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dale M. Fern</u> M.D.				ADDRESS (Street, city, town, state) <u>Aquasco, Md</u>		DATE SIGNED <u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/6/56</u>		NAME OF CEMETERY OR CREMATORY <u>ST PAUL'S</u>		LOCATION (City, town, or county) (State) <u>WALDORF, Md</u>	
24. REC'D BY REGISTRAR <u>DATE 1-4-56</u>		REGISTRAR'S SIGNATURE <u>M. S. M...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home - Waldorf</u>		ADDRESS <u>_____</u>	

RECEIVED

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THE DEATH HAS BEEN PROVED TO THE SATISFACTION OF THE BOARD OF HEALTH OF THE DISTRICT OF COLUMBIA AND THE CITY OF WASHINGTON.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

See Page No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF BURIAL PLACE

16. SIGNATURE OF DISTRICT OF COLUMBIA

17. SIGNATURE OF CITY OF WASHINGTON

18. SIGNATURE OF STATE DEPARTMENT OF HEALTH

19. SIGNATURE OF BALTIMORE, MD

20. SIGNATURE OF MARYLAND

21. SIGNATURE OF UNITED STATES

22. SIGNATURE OF WORLD

23. SIGNATURE OF HUMANITY

24. SIGNATURE OF CIVILIZATION

25. SIGNATURE OF PROGRESS

26. SIGNATURE OF KNOWLEDGE

27. SIGNATURE OF VIRTUE

28. SIGNATURE OF BEAUTY

29. SIGNATURE OF TRUTH

30. SIGNATURE OF JUSTICE

BUREAU V. S.

JAN 6 1950

RECEIVED

1/6/50

The Hunt Funeral Home - Baltimore

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00505

514

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>La Plata Md</i>				TOWN <i>Huntington Md.</i>		<i>04X.2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phys Mem. Hopt.</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Susan</i> (First) <i>Morgan</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>8</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Dec 27 1906</i>	9. AGE last birthday yrs. <i>48</i>	IF UNDER 1 YEAR Months <i>10</i> Days <i>12</i>	IF UNDER 24 HRS. Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Charles Co Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wilmer C. Morgan</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy Morgan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <i>Wilmer C. Morgan. Calvert Co</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>760.0</i> <i>respiratory failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>cerebral hemorrhage at birth</i>						<i>8 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>29 dec</i> <i>1955</i> , to <i>8 jan</i> <i>1956</i> , that I last saw the deceased alive on <i>7 jan</i> <i>1956</i> , and that death occurred at <i>4:30A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>J. M. Gibson</i>				ADDRESS (Street, city, town, state) <i>La Plata, Md.</i>		DATE SIGNED <i>1-8-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1-11-56</i>		<i>St. Joseph</i>		<i>Morganza</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>1/11/56</i>		<i>Julia H. Baxey</i>		<i>Calvert Funeral Home</i>		<i>La Plata Md.</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

2001 Form 100-100-100

1. PLACE OF DEATH

2. NAME OF DECEASED
 3. SEX
 4. AGE
 5. RACE
 6. OCCUPATION
 7. MARITAL STATUS
 8. PLACE OF BIRTH
 9. DATE OF BIRTH
 10. DATE OF DEATH
 11. TIME OF DEATH
 12. CAUSE OF DEATH
 13. MANNER OF DEATH
 14. SIGNATURE OF DECEASED
 15. SIGNATURE OF WITNESS
 16. SIGNATURE OF PHYSICIAN
 17. SIGNATURE OF CORONER
 18. SIGNATURE OF JUDGE
 19. SIGNATURE OF CLERK
 20. SIGNATURE OF NOTARY
 21. SIGNATURE OF OTHER OFFICIAL
 22. SIGNATURE OF OTHER OFFICIAL
 23. SIGNATURE OF OTHER OFFICIAL
 24. SIGNATURE OF OTHER OFFICIAL
 25. SIGNATURE OF OTHER OFFICIAL
 26. SIGNATURE OF OTHER OFFICIAL
 27. SIGNATURE OF OTHER OFFICIAL
 28. SIGNATURE OF OTHER OFFICIAL
 29. SIGNATURE OF OTHER OFFICIAL
 30. SIGNATURE OF OTHER OFFICIAL

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF DEATH

6. NAME OF DECEASED

7. SEX

8. AGE

9. RACE

10. OCCUPATION

11. MARITAL STATUS

12. PLACE OF BIRTH

13. DATE OF BIRTH

14. TIME OF DEATH

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESS

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF CORONER

BUREAU V. 2

RECEIVED

10020

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00506

515

CERTIFICATE OF DEATH

Reg. Dist. No. 100

Item 7, Film 191 1-17-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>La Plata</i>				TOWN <i>Chesee Md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phy. Menz. Hopt.</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Francis A. Penn</i>				4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>8</i> (Year) <i>1946</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Aug 27, 1884</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <i>71</i> yrs.		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alfred A Penn</i>				14. MOTHER'S MAIDEN NAME <i>Mary Bailey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Edna L Wink</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
611X IMMEDIATE CAUSE (A) <i>Cardiac failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Prostatitis, uremia,</i>				<i>5 years</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1-6</i> , <i>1956</i> , to <i>1-8</i> , <i>1956</i> , that I last saw the deceased alive on <i>1-8</i> , <i>1956</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Dr. Johnson</i> M.D. <i>La Plata, Md.</i> DATE SIGNED <i>1-8-56</i> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-10-56</i>		NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>		LOCATION (City, town, or county) (State) <i>Issue Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Julia H. Bessy</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Funeral Home</i> ADDRESS <i>La Plata</i>			
DATE <i>1/10/56</i>							

100500

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

112

Reg. Gen. No.

1. USUAL RESIDENCE (HOUSE NO. & STREET)

MARRIAGE

DATE OF BIRTH

PLACE OF BIRTH

Cause of Death

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

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BUREAU V. S.

JAN 12 1922

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BALTIMORE
STATE DEPARTMENT OF HEALTH
BALTIMORE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician, and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

516

CERTIFICATE OF DEATH

00507

Reg. Dist. No. 104

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rock Point</i>				TOWN <i>Rock Point</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>MAMIE LOMAX SIMMS</i>				<i>1 25 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>W</i>	<i>Widowed</i>	<i>March 13 1876</i>	<i>79</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>house work</i>			<i>self employed</i>		<i>Maryland</i>		<i>U.S.</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James Lomax</i>				<i>Alice Davis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>none</i>		<i>Alice J McNulty Rock Point Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
491X IMMEDIATE CAUSE (A)				<i>BRONCHIAL PNEUMONIA</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<i>1-23-56</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1-10-56</i>, to <i>1-23-56</i>, that I last saw the deceased alive on <i>1-23-56</i>, and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>E. J. Edelen</i>				DATE SIGNED <i>1-25-56</i>			
				ADDRESS (Street, city, town, state)			
				<i>LaPlata Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1-28-56</i>		<i>Trinity Cemetery</i>		<i>Newport, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Jan 31, 1956</i>		<i>Thos. J. Suarez</i>		<i>North Funeral Home</i>		<i>Waldorf Md</i>	

10003

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

Part First

1. Usual Residence (Home or Place)

2. Date of Death

3. Time of Day

*Charles
Bookman*

12 22 12

1 22 12

21mrs

31mrs

F W

BRONCHIAL PNEUMONIA 1-22-12

BUREAU V. 1

JAN 21 1956

1-22-12

1-22-12
1-22-12
1-22-12

1-10-12

1-22-12
1-22-12
1-22-12

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

517

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

00508

Reg. Dist. No. 100

1. PLACE OF DEATH- COUNTY <i>Charles</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Towpkinsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Towpkinsville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>John</i> (First) <i>Smallwood</i> (Last)		4. DATE OF DEATH (Month) <i>1-</i> (Day) <i>12</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>1-12-56</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year Months <i>4</i> Days <i>37</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Ambrose Smallwood</i>		14. MOTHER'S MARDEN NAME <i>Mary Genevieve Fowler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X Immediate cause (a) *Premature Delivery*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

9UUVVVVVX 5

BUREAU V. S.

JAN 16 1956

RECEIVED

00509

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

518

1. PLACE OF DEATH - COUNTY <u>Charles</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pamper</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pamper</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pamper</u>		STREET ADDRESS (If rural, give location) <u>Pamper</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY ANITA SWANN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 22 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>8-31-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>4</u> yrs. If under 1 year: Months <u>4</u> Days <u>22</u> Hours <u>24</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Theodore Swann</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pearl Proctor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u></u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
795.5 Immediate cause (a) <u>Unknown</u>	<u>1-22-56</u>
Antecedent cause(s) (b) <u>Only want to be with parents</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>died at 2 AM. Not ill previously</u>	<u>1-22-56</u>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE [Signature] (Degree or title) ADDRESS [Signature] DATE SIGNED 1-22-56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/24/56</u>	NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>	LOCATION (City, town, or county) (State) <u>Pamper, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/22/56</u>	REGISTRAR'S SIGNATURE <u>Julia H. Ware</u>	24. FUNERAL DIRECTOR <u>Anthony Funeral Home, Lotts, Md.</u>	ADDRESS <u></u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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BUREAU V. S.

JAN 24 1956

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